Medical Plan Options - Comparison Chart/Semi-Monthly Rates

	Basic Plan Single: $81.00 Family: $171.97		Premier Plan Single: $87.88 Family: $177.52		Value Plan Single: $42.00 Family: $147.50	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
ANNUAL DEDUCTIBLE	$ 350 Sgl $1,050 Fam	$ 350 Sgl $1,050 Fam	$100 Sgl $300 Fam	$500 Sgl $1,500 Fam	$1,500 Sgl $3,000 Fam	N/A
CO-INSURANCE ***(Hospital and Other Services)***	**You:** 10% **Plan:** 90%	**You:** 30% **Plan:** 70%	**You:** 0% **Plan:** 100%	**You:** 40% **Plan:** 60%	**You:** 30% **Plan:** 70%	N/A
ANNUAL OUT OF POCKET (OOP) MAXIMUM	**You:** $1,500 sgl/$3,000 fam	**You:** $3,500 sgl/$7,000 fam	**N/A**	**You:** $3,000 sgl/$7,000 fam	**You:** $3,000 Sgl/$6,000 Fam	N/A
OFFICE VISIT AND HOSPITAL:						
Primary Care Physician (PCP)/ Specialist	**You:** 10% after Ded. **Plan:** 90%	**You:** 30% after Ded. **Plan:** 70%	**You:** $20 copay PCP/$40 Spec + Ded **Plan:** 100%	**You:** 40% after Deductible **Plan:** 60%	**You:** 30% after Ded. **Plan:** 70%	N/A
Inpatient Hospital Copay per Admission	**You:** $100 copay + Ded. + 10% **Plan:** 90%	**You:** $300 copay + Ded. + 30% **Plan:** 70%	**You:** $100 copay + Ded. **Plan:** 100%	**You:** $300 copay + Ded. + 40% **Plan:** 60%	**You:** $100 Copay + Ded. + 30% **Plan:** 70%	
Urgent Care Copayment	**You:** $25 copay + Ded. + 10% **Plan:** 90%	**You:** 30% after Ded. **Plan:** 70%	**You:** You pay $30 + Ded. **Plan:** 100%	**You:** 40% after deductible **Plan:** 60%	**You:** 30% after Ded. **Plan:** 70%	N/A
*Emergency Room Copayment *Waived if Admitted	**You:** $100 copay + Ded. + 10% **Plan:** 90%	**You:** 30% after Ded. **Plan:** 70%	**You:** $200 copay + Ded. **Plan:** 100%	**You:** 40% after deductible **Plan:** 60%	**You:** $200 copay + Ded + 30% **Plan:** 70%	N/A
PREVENTIVE CARE:						
*Well Child Office	**You:** $0 **Plan:** 100%	NOT COVERED	**You:** $0 **Plan:** 100%	Not Covered	**You:** $0 **Plan:** 100%	N/A
*Well Adult Visit ***Ded/Copay does not apply**	**You:** $0 **Plan:** 100%	NOT COVERED	**You:** $0 **Plan:** 100%	Not Covered	**You:** $0 **Plan:** 100%	N/A
OTHER CARE:						
Chiropractic Care (limited to 20 visits/cal yr)	**You:** 10% after deductible **Plan:** 90%	NOT COVERED	**You:** $40 copay + Ded. **Plan:** 100%	Not Covered	**You:** 30% after deductible **Plan:** 70%	N/A
Physical/Speech/ Occupation Therapy (limited to 60 days for all therapies)	**You:** 10% after deductible **Plan:** 90%	NOT COVERED	**You:** $40 copay + Ded. **Plan:** 100%	**You:** 40% after plan deductible **Plan:** 60%	**You:** 30% after deductible **Plan:** 70%	N/A
Durable Medical Equipment (DME)	**You:** 10% after deductible **Plan:** 90%	**You:** 30% after deductible **Plan:** 70%	**You:** Deductible **Plan:** 100%	Not Covered	**You:** 30% after deductible **Plan:** 70%	N/A
Mental Health/Substance Abuse:	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	NOT COVERED